CORRESPONDENCE.

HERNIA OF THE URINARY BLADDER.

EDITOR ANNALS OF SURGERY.

HERNIA of the urinary bladder is sufficiently rare to make the following report interesting and valuable from the statistical stand-point.

Mrs. A., aged seventy-two years, was suddenly seized with severe pain in the right inguinal region, associated with nausea and vomiting. The vomitus, at first mucus and bile, later became slightly fæcal in character.

Dr. Gresham, of Sierra Madre, made an early diagnosis of strangulated hernia, and urgently advised operation. This was not consented to until gradually intensifying symptoms of strangulation, after twenty-four hours, led to surgical consultation, which fully concurred in the diagnosis and the necessity for immediate operation if life was to be saved.

An operating room was hastily prepared in the patient's home, a comfortable ranch house, and, assisted by Dr. George E. Abbott and two trained nurses from the Pasadena Hospital, I proceeded to operate.

The structures overlying the hernial sac were much attenuated, and my incision brought me at once to the œdematous and deeply congested sac. The constriction at the internal abdominal ring was first relieved. The sac was then opened and found to contain a loop of small intestine almost black, its peritoneal coat already lustreless and beginning to desquamate.

The use of repeated hot compresses so far restored the circulation that it was deemed safe to return the knuckle of gut to the abdominal cavity.

I next transfixed the sac at its exit from the internal abdominal ring with chromicized catgut and ligated both ways. In doing so, I was impressed with the thickness of the inner wall of the sac, but did not grasp its true significance until the sac was excised.

After snipping off the sac close to the internal ring, I endeavored to tuck the stump back into the abdomen, whereupon a clear yellow fluid welled up from the wound. The odor was distinctly urinous. The bladder was then sought for at the inner margin of the wound and grasped with forceps. When brought into plain view, an opening the size of a silver dollar was found in it.

The aperture was closed by two rows of catgut sutures. The first penetrated the entire thickness of the bladder-walls. The second row of Lembert sutures rolled in the serous surfaces and re-enforced the first row of sutures.

The bladder was now carefully tucked back into its proper location and the hernial opening closed after the Bassini method. A strand of catgut in contact with the line of suture in the bladder-wall was brought out at the lower angle of the skin incision.

A self-retaining catheter was introduced into the bladder, and continuous drainage practised for one week. The sutures were then removed from the skin wound, which had healed primarily, and the catheter was also removed after testing the bladder for irrigation. Four ounces of boracic acid solution were several times forced into the bladder by gravity, and the entire quantity recovered each time without discomfort to the patient.

Recovery was complete and uninterrupted, save by a mild cystitis.

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THE EXPOSURE OF THE POSTDUODENAL PORTION OF THE COMMON BILE DUCT.

EDITOR ANNALS OF SURGERY.

I NOTICE in the September number of the ANNALS a letter from Dr. C. M. Cooper describing shortly a new method of reaching the postduodenal portion of the common bile duct. The method is thoroughly practical and useful. In the *Revue de Chirurgie,* June, 1896, Professor Vautrin, of Nancy, gives a very full and clear description of the procedure and an account of its use in several cases.

J. F. BINNIE.

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